City of Houston Department of Health and Human Services
Bureau of Laboratory Services
2250 Holcombe Blvd,
Houston, TX 77030
(832) 393 - 3900

LABORATORY REPORT for PM_{10} FILTER

Name of Submitter:_____ **Address: Bureau of Pollution Control and Prevention 7411 Park Place Houston, TX 77087**

Date Submitted:_____

Sample Description: PM-10 Filter **Analysis Requested: Particulates**

Site: _____ **Sample Date:** _____ **Minutes Sampled:** _____

Received By:_____ **Date:**_____ **Title: Chemist**

Weighed By:_____ **Date:**_____ **Title: Chemist**

Test Method: 40CFR Part 50, Appendix J

Comments:

_____

Filter Number	Air Volume (m^3)	Particulates Collected (g)	Final Result (ug / m^3)

Additional Lab Information:_____

_____

Date Reported: _____ **Supervisor's Name:**_____

Signature:_____

End of Report

Laboratory Chain of Custody / Lead Test Report

Client Address:

Case Number: _____ **Risk Assessment** ☐ **Clearance** ☐

Grant /Program: _____

Sampling Date: _____ **Sample Type:** _____

Sample Collected By: _____ **License #** _____

Analysis Requested: Pb in Soil **Test Method (Modified):** EPA 200.2 / 7420 **MRL:** 20ug/g

Pb **Test Method (Modified):** _____ **MRL:** _____

Remarks: Laboratory results meet quality control standards.

Sample Number (Field)	Sample Number (Lab)	Bare or Covered	Lab Result	Unit	Remarks

Total number of samples on this page: _____

Additional Lab information: _____

FOR LABORATORY USE ONLY

Date Received: _____ **By:** _____ **Title:** Chemist

Date Digested: _____ **By:** _____ **Title:** Chemist

Date Analyzed: _____ **By:** _____ **Title:** Chemist

Date Reported: _____ **Supervisor (Print):** _____

Supervisor's Signature: _____

Analyses performed by:
Houston Department of Health and Human Services
Bureau of Laboratory Services
2250 Holcombe Blvd., Houston, TX 77030
832-393-3900
Revision: 6 Date: 02-13-2012

Field No:_____

CITY OF HOUSTON
Inorganic Lab Report

Lab Date/Time Stamp

Houston Department of Health and Human Services
Bureau of Laboratory Services
2250 Holcomb Blvd
Houston, TX 77030
832-393-3900

SUBMITTER: Bureau of Pollution Control & Prevention
7411 Park Place, Houston, TX 77087
832-393-5730

Aqueous Matrix

SAMPLE LOCATION:_____ STATION ID:_____

SAMPLER:_____ SAMPLE RECEIVED IN ICE _____

DATE COLLECTED:_____ PRESERVATION CHECKED _____ Initials _____

TIME COLLECTED: _____ pH: <2 yes_____ no_____

	Laboratory Analysis		Suffix*	Date/Time of Analysis	Analyst	Test Method	MRL mg/L
1.	pH @ Temp. °C		NA1			SM 4500-H⁺B	N/A
2.	Conductivity	µS	NA1			SM 2510 B	N/A
3.	TSS	mg/L	NA1			SM 2540 D	4
4.	Cl^-	mg/L	NA1			EPA 300.0	5
5.	$N\text{-}NO_3$	mg/L	NA1			EPA 300.0	0.02
6.	SO_4	mg/L	NA1			EPA 300.0	5
7.	$N\text{-}NH_3$	mg/L	A1			EPA 350.1	0.1
8.	$T\text{-}PO_4$	mg/L	A1			EPA 365.1	0.02

Note: This report contains only the results for the sample described above. This report can not be reproduced, except in full.

*Suffix – NA1, NA2, is added to sample numbers for Non-Acidified samples. A1, A2, for Acidified samples.

Additional Laboratory Information: _____

_____

Date Reported:_____ Laboratory Supervisor Name: _____ Signature:_____

NELAC Certificate Number: T104704253-11-4

END OF REPORT

Place Sample Number Tag Here

Laboratory Chain of Custody / Lead Test Report
Wipe Samples Testing

Client Address: Bureau of Community and Children's Environmental Health
8000 N. Stadium Drive,2nd floor, Houston, TX 77054
Office: 832-393-5141 Fax: 832-393-5210

Case Number: _____ **Risk Assessment** ☐ **Clearance** ☐

Grant /Program: _____

Sampling Date: _____ **Sample Type:** Wipe

Sample Collected By: _____ **License #** _____

Analysis Requested: Pb in wipe **Test Method (Modified):** 40CFR Part 50 App.G **MRL:** 10ug/wipe

Remarks: Laboratory results meet quality control standards. Field blanks for wipes have not been subtracted from values.

Sample Number (Field)	Sample Number (Lab)	Location Sampled	Component Sampled	Dimensions Of Surface Sampled	Total Surface Area Sampled	Lab Result (ug/ft^2)

Total number of samples on this page: _____

I certify that the wipes used to collect these samples conform to the specifications of ASTM E 1792.

By: _____ **Date:** _____

FOR LABORATORY USE ONLY

Date Received: _____ **By:** _____ **Title:** Chemist

Date Digested: _____ **By:** _____ **Title:** Chemist

Date Analyzed: _____ **By:** _____ **Title:** Chemist

Date Reported: _____ **Supervisor (Print):** _____

Supervisor's Signature: _____

Analyses performed by:
Houston Department of Health and Human Services
Bureau of Laboratory Services
2250 Holcombe Blvd., Houston, TX 77030
832-393-3900
Revision: 6 Date: 02-13-2012

Laboratory Chain of Custody / Lead Test Report

Client Address: Bureau of Community and Children's Environmental Health
8000 N. Stadium Drive,2nd floor, Houston, TX 77054
Office: 832-393-5141 Fax: 832-393-5210

Case Number: _____ **Risk Assessment** ☐ **Clearance** ☐

Grant /Program: _____

Sampling Date: _____ **Sample Type:** _____

Sample Collected By: _____ **License #** _____

Analysis Requested: Pb in Soil **Test Method (Modified):** EPA 200.2 / 7420 **MRL:** 20ug/g

Pb _____ **Test Method (Modified):** _____ **MRL:** _____

Remarks: Laboratory results meet quality control standards.

Sample Number (Field)	Sample Number (Lab)	Bare or Covered	Lab Result	Unit	Remarks

Total number of samples on this page: _____

Additional Lab information: _____

FOR LABORATORY USE ONLY

Date Received: _____ **By:** _____ **Title:** Chemist

Date Digested: _____ **By:** _____ **Title:** Chemist

Date Analyzed: _____ **By:** _____ **Title:** Chemist

Date Reported: _____ **Supervisor (Print):** _____

Supervisor's Signature: _____

Analyses performed by:
Houston Department of Health and Human Services
Bureau of Laboratory Services
2250 Holcombe Blvd., Houston, TX 77030
832-393-3900
Revision: 6 Date: 02-13-2012

Field No:_____

CITY OF HOUSTON
Inorganic Lab Report

Lab Date/Time Stamp

Houston Department of Health and Human Services
Bureau of Laboratory Services
2250 Holcombe Blvd
Houston, TX 77030
832-393-3900

SUBMITTER:_____
ADDRESS:_____

Aqueous Matrix
Sample Received on ice_____
pH < 2.0 y / n

Sampled By:_____ Date Sampled:_____ Time Sampled:_____

Site Address:_____ Site ID/Permit#:_____

Sample Matrix/Description_____

Additional Information_____

Relinquished by:_____ Received by:_____ Date:_____
Relinquished by:_____ Received by:_____ Date:_____

Reporting Unit: mg/L (aqueous)

	Analysis	Results	Suffix*	Analysis Date	Analyst	Test Method	MRL mg/L
1	pH	@ °C	NA1			SM 4500-H*B	N/A
2	Ag		M1			6010B/3005A	0.01
3	Cd		M1			6010B/3005A	0.01
4	Cr		M1			6010B/3005A	0.01
5	Cu		M1			6010B/3005A	0.01
6	Mn		M1			6010B/3005A	0.01
7	Ni		M1			6010B/3005A	0.03
8	Pb		M1			6010B/3005A	0.05
9	Zn		M1			6010B/3005A	0.03
10	Hg		M1			EPA 7470A	0.0005
11	O&G		OG1			EPA 1664	16
12							
13							

Note. All data reported meets or exceeds all QC criteria unless noted below. *Suffix is added to sample numbers as explained in the QA plan.

Additional Laboratory Information: _____

_____

Date Reported:_____ Laboratory Supervisor Name: _____ Signature:_____

END OF REPORT

Place Sample Number Tag Here

Field No:_____

CITY OF HOUSTON
Inorganic Lab Report

Lab Date/Time Stamp

Houston Department of Health and Human Services
Bureau of Laboratory Services
2250 Holcombe Blvd
Houston, TX 77030
832-393-3900

SUBMITTER:_____
ADDRESS:_____

Soil Matrix
Sample Received on ice_____

Sampled By:_____ Date Sampled:_____ Time Sampled:_____

Site Address:_____ Site ID/Permit#:_____

Sample Matrix/Description_____

Additional Information_____

Relinquished by:_____ Received by:_____ Date:_____
Relinquished by:_____ Received by:_____ Date:_____

Reporting Unit: mg/Kg (soil)

	Analysis	Results	Suffix*	Analysis Date	Analyst	Test Method	MRL mg/Kg
1	pH	@ °C	S1			EPA 9045	N/A
2	Ag		S1			6010B/3050B	2.0
3	Cd		S1			6010B/3050B	2.0
4	Cr		S1			6010B/3050B	5.0
5	Cu		S1			6010B/3050B	5.0
6	Mn		S1			6010B/3050B	5.0
7	Ni		S1			6010B/3050B	10.0
8	Pb		S1			6010B/3050B	10.0
9	Zn		S1			6010B/3050B	10.0
10	Hg		S1			EPA 7471A	0.5
11	O&G		S1			EPA 9071B	800
12							
13							

Note: All data reported meets or exceeds all QC criteria unless noted below. *Suffix is added to sample numbers as explained in the QA plan.

Additional Laboratory Information: _____

_____

Date Reported:_____ Laboratory Supervisor Name: _____ Signature:_____

END OF REPORT

Place Sample Number Tag Here

Field No:_____

CITY OF HOUSTON
Inorganic Lab Report

Lab Date/Time Stamp

Houston Department of Health and Human Services
Bureau of Laboratory Services
2250 Holcombe Blvd
Houston, TX 77030
832-393-3900

SUBMITTER: Bureau of Pollution Control & Prevention
7411 Park Place, Houston, TX 77087 832-393-5730

Air Filters

Sampled By:_____ **Date Sampled:**_____ **Time Sampled:**_____

Site Address:_____ **Site ID/Permit#:**_____

Sample Matrix/Description_____

Additional Information_____

Relinquished by:_____ **Received by:**_____ **Date:**_____
Relinquished by:_____ **Received by:**_____ **Date:**_____

Reporting Unit: µg/filter

	Analysis	Results	Suffix*	Analysis Date	Analyst	Test Method	MRL µg/filter
1	pH	@ °C					N/A
2	Ag		F1			6010B/NIOSH 7303	0.5
3	Cd		F1			6010B/NIOSH 7303	0.5
4	Cr		F1			6010B/NIOSH 7303	0.5
5	Cu		F1			6010B/NIOSH 7303	0.5
6	Mn		F1			6010B/NIOSH 7303	0.5
7	Ni		F1			6010B/NIOSH 7303	1.5
8	Pb		F1			6010B/NIOSH 7303	2.5
9	Zn		F1			6010B/NIOSH 7303	1.5
10	Fe		F1			6010B/NIOSH 7303	10
11	Co		F1			6010B/NIOSH 7303	0.5
12	Hg		F1			OSHA ID-145	0.05
13							

Note: All data reported meets or exceeds all QC criteria unless noted below. *Suffix is added to sample numbers as explained in the QA plan.

Additional Laboratory Information: _____

_____

Date Reported:_____ Laboratory Supervisor Name: _____ Signature:_____

END OF REPORT

Place Sample Number Tag Here

CITY OF HOUSTON
Organic Lab Report

Field No: _____

Lab Date/Time Stamp

Houston Department of Health and Human Services
Bureau of Laboratory Services
2250 Holcombe Blvd.,
Houston, TX 77030. Tel# 832 393-3927

SUBMITTER: _____
ADDRESS: _____

Sampled by: _____ Date sampled: _____ Time sampled: _____

Site Address: _____

Sample Matrix / Description: _____ SAMPLE RECEIVED PLACED IN ICE _____
Soil collection method : ____ Bulk sampling jars ____ Hermitically sealed pre-weighed vials
Additional Information: _____

Relinquished by: _____ Rec'd by: _____ Date: _____

Reporting Unit: mg/L for aqueous mg/kg for soil

Analysis	Result	Suffix*	Analyst	Date	Modified Method
1. Semi-Volatiles		SV			EPA 8270
2. Volatiles		VOC			EPA 8260B
3. Pesticides					EPA 8080
4. BTX/BTEX					EPA 8260B
5. TPH (nC_6 to nC_{12})		TPH			TCEQ 1005
6. TPH (>nC_{12} to nC_{28})		TPH			TCEQ 1005
7. TPH (>nC_{28} to nC_{35})		TPH			TCEQ 1005
8. TPH (nC_6 to nC_{35})		TPH			TCEQ 1005
9. Propylene Glycol					
10. Ethylene Glycol					

Note: All data reported meets or exceeds all QC criteria unless noted below.
* Suffix VOC 1, VOC 2, VOC3 is added to sample numbers for volatile samples and replicates and TPH 1, TPH 2, TPH 3 to numbers for TPH samples and replicates, SV 1, SV 2, SV 3 for semi - volatile samples and replicates. Only VOC and TPH are NELAC certified parameters.

Additional Laboratory Information, if appropriate, is provided on a separate sheet: **Note:** Results are from samples collected in bulk sampling jars rather than hermetically sealed vials. If prior sample information is not available or if nC6 to nC12 hydrocarbons are suspected to be present in the soil samples, sampling should be done in hermetically sealed vials using coring device.
Under the 30 TAC 334, Petroleum Storage Tank(PST) rule, samples can be collected by bulk sampling method for samples related to PST.

Bulk sampling is not suitable for soil containing low concentrations of volatiles.

Date Reported: _____ Lab Supervisor: Name: _____ Signature : _____

NELAC Certificate Number: T104704253-08-TX (For VOC & TPH only) END OF REPORT

Place Sample Number Tag Here

_____
Analysis started

NELAC Recognized Accreditation
Certificate #
T104704253

Date and Time received: _____

E.coli & Total Coliforms

Analysis Report

The results contained in this report apply **only** to the samples described below

CITY OF HOUSTON
Health and Human Services Department
Bureau of Laboratory Services
Water & Dairy Laboratory
2250 Holcombe Blvd.
Houston, TX 77030

Submitter _____

Account Number _____

Address _____

_____

Phone _____ FAX _____ Email _____

Description of Sample _____

Date & Time of collection _____

Collected by _____

Delivered by _____

Received by _____

Condition of Seals _____

Analyst _____/_____
set up read

Lab Sample Number	Cl_2 mg/L	Total coliforms MPN/100 ml	E. coli MPN/100 ml

Method performed: E. coli : IDEXX Colilert-18® - Quanti-Tray®/2000

Note: Data reported meets or exceeds all NELAC required QC criteria unless noted below

Laboratory notes: _____

Reported by _____ Signature _____ Date Reported _____
Laboratory Supervisor/Microbiologist (circle one)

Rev 02/11

NELAC Recognized Accreditation Certificate # **T104704253**

_____
Analysis started

The results contained in this report apply **only** to the samples described below

Surface Water Monitoring Report
Clean Rivers Program

Date and Time received: _____

CITY OF HOUSTON
Health and Human Services Department
Bureau of Laboratory Services
2250 Holcombe Blvd.
Houston, TX 77030

Collected by _____

Armand Bayou **Run 19**

	STATION NUMBER	SITE LOCATION	TIME SAMPLED	Cl_2 mg/L	LAB SAMPLE NUMBER	E. coli MPN/100ml	Enterococcus MPN/100 ml
1	**11172** HG-192 20729	Little Vince Bayou @ N. Main St			**536 H**		
2	**11405**	Armand Bayou @ Fairmont Pkwy			**578 F**		
3	**11404**	Armand Bayou @ Genoa Red Bluff			**578 L**		
4	**17487**	Willow Spring Bayou @ Bandridge			**578 D**		
5	**17486**	Big Island Slough @ Hill Ridge			**579 B**		
6	**11503**	Armand Bayou @ Bay Area Blvd			**619 A**		
7	**17485**	Horsepen Bayou @ Penn Hills			**618 F**		

Methods performed: E. coli: IDEXX Colilert® -18(QT-2000) **Enterococcus** : IDEXX Enterolert™(QT-2000)

Note: Data reported meets or exceeds all NELAC required QC criteria unless noted below

Laboratory notes: _____

Analyst _____/_____

Name_____Signature_____Date Reported _____
Laboratory Supervisor/Microbiologist II (circle one)

_____
Analysis started

NELAC Recognized Accreditation Certificate # **T104704253**

Date and Time received: _____

Enterococcus

Analysis Report

The results contained in this report apply **only** to the samples described below

CITY OF HOUSTON
Health and Human Services Department
Bureau of Laboratory Services
Water & Dairy Laboratory
2250 Holcombe Blvd.
Houston, TX 77030

Submitter _____

Account Number _____

Address _____

_____

Phone _____ FAX _____ Email _____

Description of Sample _____

Date & Time of collection _____

Collected by _____

Delivered by _____

Received by _____

Condition of Seals _____

Analyst _____ / _____
set up read

Lab Sample Number	Cl_2 mg/L	Enterococcus MPN/100 ml

Method performed: **Enterococcus**: IDEXX Enterolert® - Quanti-Tray®/2000

Note: Data reported meets or exceeds all NELAC required QC criteria unless noted below

Laboratory notes: _____

Reported by _____ Signature _____ Date Reported _____
Laboratory Supervisor/Microbiologist (circle one)

Rev 02/12

Drop off hours: 8am-4pm M-F.
Pay by check, money order, CC or COH Account.
* Sample MUST be received within 30 hours of collection

Drinking Water Submission Form

Houston Department of Health and Human Services
Bureau of Laboratory Services
www.houstontx.gov
Water Laboratory 2250 Holcombe Blvd.
Houston, TX 77030 Phone: 832.393.3939
NELAP Ceriflcate # T104704253
USE BLUE OR BLACK INK ONLY NO PENCIL

Date & Time received

Public Systems Only: 7-digit PWS ID # ☐☐☐☐☐☐☐
Assigned by TCEQ

Name of Public Water System: _____

Payment Method:
COH Account No:
__/__/__/__/__/__/__
Check or Money Order #

Return Address

Name _____
Address _____
City _____ **State** _____ **Zip** _____
Phone (_____) _____ **Email** _____

*The results contained in this report apply **only** to the 1 (one) sample described below. Please retain this report for your records.*

SAMPLE SITE / COLLECTION DATE & TIME *(REQUIRED)*

DATE / TIME ANALYSIS STARTED

Date Collected _____/_____/_____ **Time Collected** _____ **AM / PM**
Month Day Year

Sample Site (address or other description, not sample site #) _____

Sampler Name _____ **Phone** _____ **County** _____

SYSTEM TYPE
CHECK ONLY 1 BOX

☐ **Public**
☐ **Private/ Individual**
☐ **Other:** _____

SAMPLE TYPE
PUBLIC WATER SYSTEMS ONLY
CHECK ONLY 1 BOX

☐ **Routine / Distribution** ☐ **Construction**
☐ **Raw: well #** _____ ☐ **Special**
☐ **Repeat for sample #** _____

REPEAT SAMPLES are required when Coliform organisms are **FOUND** in Routine / Distribution samples

Water Source:
☐ **Groundwater (well)**
Depth of well _____ **ft**
☐ **Surface Water (Lake, River)**

DISINFECTANT RESIDUAL:
_____ **mg / L**
☐ **Free chlorine OR** ☐ **Total chlorine**

Routine/Distribution samples will NOT be analyzed with out a Disinfectant Residual recorded

LABORATORY RESULTS
Test Method Used: SM9223B

☐ Chlorine content of the sample was not determined before analysis

COLIFORM BACTERIA ORGANISMS:

Total Coliform
☐ FOUND ☐ NOT FOUND

E. coli
☐ FOUND ☐ NOT FOUND

ANALYZED BY: _____ READ BY: _____

☐ **UNSUITABLE FOR ANALYSIS** (see below)
- ☐ Sample too old. Not received within **30 hours** of collection
- ☐ Sample leaked / bottle cracked in transit
- ☐ Quantity insufficient for analysis (100mL required)
- ☐ Form Incomplete / (w/Errors circled)
- ☐ Inconclusive result
- ☐ Sample has excessive color / turbidity
- ☐ Excessive Chlorine residual
- ☐ Other reason: DESCRIBE _____

Water of satisfactory bacteriological quality must be free of coliform organisms
NOTE: Data reported meets or exceeds all NELAC required QC criteria unless noted above.

Reported by: _____ **Signature:** _____ **Date:** _____
Laboratory Supervisor/Microbiologist / Other

Submit to TCEQ / Public Drinking Water MC – 155, PO Box 13087, Austin, TX 78711512-239-4691
Fax Positive to 512.239.3666

rev0311

Correct DW Form 8/2/17.

CITY OF HOUSTON

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CONSUMER HEALTH SERVICES BUREAU
8000 N STADIUM DR 2ND FLOOR
HOUSTON, TX 77054
832-393-5100

FOOD MICROBIOLOGY REPORT

Account # _____

Laboratory Sample ID: _____

Date Received: _____ Date/Time Collected:

Sample Accepted by: _____ Name of complainant: _____

Description of Sample: **(1) Name of Product:**

(2) Point of Collection/Address:

(3) Manufacturer:

Was anyone ill? Yes ☐ How many? _____ Attending Physician, if any: _____
No ☐

Describe illness (symptoms, time of onset, duration):

_____

_____

If complaint is about filth, chemicals, foreign objects (glass, hair, etc.), describe fully:

_____

_____

Send report to:

LABORATORY FINDING

1. SID:
   Sample Description:
   Receipt TC: °C
   RESULTS:

   SPC/ml or g:
   PCC/ml or g:

2. SID:
   Sample Description:
   Receipt TC: °C
   RESULTS:

   SPC/ml or g:
   Staph. Aureus/g:
   Total Coliform MPN/100 ml
   Fecal Coliform MPN/100 ml

Date/Time Received

Houston Department of Health and Human Services
Bureau of Laboratory Services
2250 Holcombe Blvd.
Houston TX 77030-1715
832-393-3939

Microbiology Report: Dental Water Reservoir

Submitter: Johanna K. DeYoung, DDS, MPH
8000 North Stadium Drive #26
Houston TX 77054-1823
Phone: 832-393-4876/713-859-2132
Fax: 713-794-3111
Johanna.deyoung@houstontx.gov

Dental Clinic: _____

Description of Sample, e.g., Chair 3: _____

Date and Time of Sample Collection: _____

Collected by: _____

Delivered by: _____

Lab Number	SPC/ml

Comments: _____

_____

_____

_____ _____

Test Performed Tech Laboratory Supervisor/Date

Revised: 8/8/12

Report to:

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

GRADE "A" RAW FOR RETAIL DAIRY

Laboratory Identification		Date	Time	Temp.	Accepted by
Location	Collection		a.m. p.m.		
	Plant		a.m. p.m.		
ID. No.	Sanitarian		a.m. p.m.		
	Laboratory		a.m. p.m.		

SSF

ANALYST IDENTIFICATION →

Sample No.	Temp. °F	Brand and Plant Code No.	Prod. Code Date	Size	Kind	State Code No.	Standard Plate Count			Coliform Count CPC/PCC	DMSCC/ESCC		Growth Inhibitors		Freezing Point – °H	Remarks
							1:10	1:100	SPC per ml / or g.	1.0 per ml. or per g.	SCC Raw Count	Somatic Cell Count / ml	Not Found	Found		

Report to: Public Health Region:
Texas

TEXAS DEPARTMENT OF HEALTH

RETAIL DAIRY PRODUCTS ANALYSIS

TDH

	Date	Time	Temp.	Accepted by
Collection		a.m. p.m.		
Plant		a.m. p.m.		
Sanitarian		a.m. p.m.		
Laboratory		a.m. p.m.	°C	

Laboratory Identification
Location
Id. No.

ANALYST IDENTIFICATION →

Sample No.	Temp. °C	Brand and Plant Code No.	Product Code Date	Size	Code	Kind	Code	Standard Plate Count 1:10	Standard Plate Count 1:100	Standard Plate Count S.P.C. per ml. or g.	Coliform Count 1.0	Coliform Count per ml. or per g.	Growth Inhibitors Phos.	Growth Inhibitors Not Found	Growth Inhibitors Found. See remarks	Freezing Point — °H	B.F.	Remarks
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

BULK MILK ANALYSIS

Report To: _____
PHR: _____
_____, Texas

Laboratory Identification		Reported			
		Date	Time	Temp	Accepted by
Location	Collection		a.m. p.m.		
	Plant		a.m. p.m.		
ID No.	Sanitarian		a.m. p.m.		
	Laboratory		a.m. p.m.		

ANALYST IDENTIFICATION

Sample No.	Temp. °F	Producer Producer No.	STANDARD PLATE COUNT 1:100	1:1000	S.P.C. / ml.	Somatic Cell Count / ml.	Growth Inhibitors Not Found	Found see remarks	Freezing Point - °H	Remarks
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										

Form No. G-84 (Rev. 02-08/05)

TEXAS DSHS DAIRY WATER FORM

Testing Laboratory: Houston Department of Health and Human Services
Bureau of Laboratory Services

Address: 2250 Holcombe Blvd
Houston, TX 77030

Phone: 832.393.3939

Lab ID#: 48012

Receipt Temperature: °C
Lab Specimen #:
Date / Time Received:
Date / Time Analyzed:
Date / Time Reported:

SAMPLE IDENTIFICATION

Plant / Farm Permit #: _____ Plant / Farm Name: _____

Send Sample Results To:

Sanitarian: _____

Address: _____

City, State, Zip: _____

Phone: _____

SAMPLE SITE / COLLECTION DATE & TIME

Date/Time Collected: ____/____/____ (Month / Day / Year) ____:____ (Time of Day) ☐ am ☐ pm

Sample Site: _____

Sanitarian/Phone: _____

SYSTEM TYPE

- ☐ Farm
- ☐ Plant
- ☐ Other _____

SAMPLE TYPE

- ☐ Well
- ☐ Public
- ☐ Reclaim
- ☐ Other _____

Recirculated:
- ☐ Chill
- ☐ Glycol
- ☐ Sweetwater

WATER SOURCE

- ☐ Groundwater (well)
- ☐ Surface
- ☐ Other _____

TEST REQUESTED:

☐ Coliform Organisms ☐ Heterotrophic Plate Count (HPC)

LABORATORY REPORT : *(Laboratory Use Only-DO NOT write below)*

Coliform Organisms:

Test Method Used: ☐ *Colilert P/A* ☐ *MTF (Multiple Tubes or P/A)* ***Analyst:*** _____

Total Coliform	☐ *NOT FOUND <1 or <1.1 /100 mL*	☐ *FOUND ≥ 1 or ≥1.1 / 100 mL*
E. coli	☐ *NOT FOUND <1 or <1.1 /100 mL*	☐ *FOUND ≥ 1 or ≥1.1 / 100 mL*

Heterotrophic Plate Count / mL at 35°C:

Test Method Used: ☐ *Petrifilm* ☐ *Pour Plate* _____ *CFU / mL*

SAMPLE UNSUITABLE FOR ANALYSIS

- ☐ Sample too old. Not received within 30 hours of collection.
- ☐ Quantity insufficient for analysis (100 mL required)
- ☐ Form incomplete / date discrepancy (CIRCLE errors)
- ☐ Excessive turbidity on MTF – resubmit for HPC.
- ☐ Sample has excessive color / turbidity.
- ☐ Sample leaked / bottle cracked in transit.
- ☐ Other reason. DESCRIBE: _____

Copies: Sanitarian, DSHS Milk Group, Laboratory

Rev. 5/08

TSB/NUTRIENT BROTH

QC FREQUENCY: Each Lot on receipt

QC PROCEDURE: Incubate one uninoculated bottle per lot received @ 35± 0.5 for 48 hours and check for growth.

ACCEPTABLE RESULTS:

ACCEPTABLE = A, No Growth

UNACCEPTABLE = U, Discontinue use and Notify Supervisor immediately

Date Received	Date Tested	Uninoculated	Acceptability	Total # Received	Lot #	Tech	COMMENTS
12/9/2009	12/15/2009	NO GROWTH	A	20	303214-1	TN	

Reviewed by: _____ **Date:** _____ **Reviewed by:** _____ **Date:** _____

Reviewed by: _____ **Date:** _____ **Reviewed by:** _____ **Date:** _____

Reviewed by: _____ **Date:** _____ **Reviewed by:** _____ **Date:** _____

BI -ANNUAL QC PIPETORS DATE:

PIPETTOR CALIBRATION
10 weighings with separate tips for each weighing

To be done every six months

3M 1mL Electronic Pipettors

Month:
Pipettor:
Analyst:

Average: 0
Deviation % #DIV/0!
Corrective Action:_____

Month:
Pipettor:
Analyst:

Average: 0
Deviation % #DIV/0!
Corrective Action:_____

Month:
Pipettor: 1mL # 3
Analyst:

Average: 0
Deviation % #DIV/0!
Corrective Action:_____

Month:
Pipettor:
Analyst:

Average: 0
Deviation % #DIV/0!
Corrective Action:_____

Month:
Pipettor:
Analyst:

Average: 0
Deviation % #DIV/0!
Corrective Action:_____

Month:
Pipettor:
Analyst:

Average: 0
Deviation % #DIV/0!
Corrective Action:_____

City of Houston Health Department
Water & Dairy Laboratory
2250 Holcombe Blvd., Houston, TX

INCUBATOR # 1B

JULY 2012

Brand Precision
Acceptable Range 31.0-33.0 °C
Location Room B148C
Thermometer # 29 CF = 0.0
Thermometer # 25 CF = - 0.4

AM TEMPERATURES TAKEN BEFORE 9:00 AM PM TEMPERATURES TAKEN AFTER 1:00 PM

Date	AM				Init.	PM				Init
	Upper		lower			Upper		lower		
	TR	w/CF	TR	w/CF		TR	w/CF	TR	w/CF	
1	SUNDAY									
2										
3										
4						HOLIDAY				
5										
6										
7						SATURDAY				
8	SUNDAY									
9										
10										
11										
12										
13										
14						SATURDAY				
15	SUNDAY									
16										
17										
18										
19										
20										
21						SATURDAY				
22	SUNDAY									
23										
24										
25										
26										
27										
28						SATURDAY				
29	SUNDAY									
30										
31										

TR = thermometer reading **w/CF** = with correction factor

Notes_____

Reviewed by _____ Date _____

rev0712

DIRECT MICROSCOPIC SOMATIC CELL COUNT
ANNUAL SINGLE STRIP FACTOR

MICROSCOPE TYPE:
Binocular with 1.8 mm oil immersion objective, rack and pinion sub-stage, condenser with iris diaphragm.
Oculars, 10X (12X or 12.5X) Huygenian or wide field.
Optics provides a Single Strip of 6070 or smaller.

1. Using a stage micrometer (0.1 and 0.01 divisions) measure the field diameter (D) of oil immersion objective lens in mm.

   Each analyst measures field diameter, and round to three significant figures.

   D = _____ mm

2. Calculation of Single Strip Factor.

   SSF= 10,000 / (11.28 X D)

   SSF= 10,000 / (11.28 X_____) = _____(round to three sig. figures)

   SSF = _____

3. Compute DMSCC/mL, multiply number of cells counted (strip count) by the SSF.

4. Report somatic cell counts as DMSCC/mL, record only first two left hand digits, round as necessary.

NAME_____ DATE_____

MICROSCOPE # _____

THERMOMETER CALIBRATION REQUEST
From Water and Dairy

DATE SUBMITTED: _____ DATE COMPLETED: _____

Therm #	Model/Serial #	Two Point Calibration Temperatures		Date of last calibration (if known)	Date to be calibrated by?

rev.06072012